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Issue Date: 16 January 2007

Case No.: 2001-LHC-01125

In the Matter of

P.P.,
Claimant,

v.

UNIVERSAL MARITIME SERVICE CORP.,
Employer,

and

SIGNAL MUTUAL INDEMNITY ASSOCIATION, LTD.,
Carrier.

Appearances: Robert J. De Groot for Claimant
Christopher J. Field for Employer and Carrier

Before: PAUL H. TEITLER
Administrative Law Judge

DECISION AND ORDER DENYING CLAIMANT'S MOTION FOR MODIFICATION

This proceeding involves a claim for benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S. § 901 et seq. ("the Act"), and the regulations promulgated there under. A hearing was held before me in New York City on January 18, 2006.

At the hearing, Claimant's exhibits 1-12 and Employer's exhibits 1-4 were admitted into evidence. Post-hearing, Employer submitted two additional Exhibits, marked as EX 5 and 6. Prior exhibits were made a part of the record. Post-trial briefs were submitted on behalf of both parties.

PROCEDURAL HISTORY

This claim was initially denied on March 26, 1999, and appealed to the Board who affirmed the Decision and Order. Claimant moved for Modification on January 17, 2001.

Claimant failed to comply with Orders issued by this Court and on June 24, 2002, I issued an Order dismissing the case. On July 8, 2002, Claimant moved for Reconsideration of the dismissal. I denied this request on July 23, 2002. Claimant appealed this denial, and the Board vacated and remanded my decision on June 30, 2003. In an Order dated March 25, 2004, I addressed the Board's questions and affirmed the dismissal. I also, by separate Order issued on the same date, Certified Facts to the United States District Court of New Jersey. Claimant moved for Reconsideration on April 2, 2004, which I denied on April 13, 2004. Claimant again appealed to the Board. The Board issued a Decision and Order on April 29, 2005, vacating my denial of Claimant's most recent request for Reconsideration, and remanding the case to me for proceedings consistent with its Order. The Board did not have jurisdiction to review the Certification of Facts.

The Board's decision vacated my Denial of a Motion for Reconsideration, and vacated my dismissal of the case. Therefore the present case is again one that addresses modification as relates back to my 1999 Decision and Order. As Claimant's counsel stated at the January 2006 hearing, the current proceeding is a modification "predicated both upon mistake of finding of fact and/or a change in condition … since [the] decision of March 30, 1999." (Tr. at 5).

EVIDENCE

Claimant's Testimony

Claimant testified that he injured his left knee, low back and left shoulder in the 1993 accident, and re-injured the same areas in the 1996 accident, plus his right shoulder and neck/cervical back which has caused headaches. (Tr. at 54-55). He asserted that his condition has worsened since 1997, with worsened back and left knee pain. (Tr. at 24-25). He began seeing Dr. Charko in 2000. Dr. Charko recommended surgery on Claimant's back and left knee, and diagnosed Claimant with carpal tunnel syndrome in his hand. Claimant testified that he injured his hand the 1993 accident, and maintained that he included this in his testimony at the time, which he recalled as being an injury to his "whole left side." (Tr. at 26). He stated that he is afraid to proceed with the recommended surgeries. (Tr. at 26).

Claimant testified that he can not work due to limitations with sitting, standing, and attention span. (Tr. at 27). He feels his medication, BusPar, affects his alertness, although he stated he is not sure how this medication affects him. (Tr. at 32). He has not sought work since November 1997. (Tr. at 39). At home he mows the lawn on a "self-propelled" lawn mower, takes out the garbage and runs errands. (Tr. at 28-29). He later stated that he is able to do all of the activities around the house that he did prior to the accident, just at a slower pace. (Tr. at 40).

Claimant stated that he remembers receiving treatment, consisting of a hot pack, for his left shoulder after the 1993 accident, and maintained that he has been alleging this injury all along. (Tr. at 30-32).

Concerning his prior testimony, Claimant agreed that he testified to constant lower back pain, constant left knee pain, constant left leg numbness, and pain in his right shoulder. (Tr. at 34-35). He also recalled testifying that he could not walk further than a block, sit for longer than

ten minutes, lift with his right arm, and always had to use a cane. (Tr. at 35-37). But he agreed that at the present hearing he was sitting for longer than ten minutes and did not always use a cane. He also testified that he lifts with his right arm, just more than he does with his left, but maintained that his right arm is in the same condition it was in at the time of the prior hearing. He then stated that he "can't lift with both arms." (Tr. at 35-36). Claimant testified that presently he does not always use his cane, but stated that he always has a limp. (Tr. at 37-38). An interpreter was utilized at the prior hearing, but not at the current hearing. Claimant testified that his English had not improved since the time of the prior hearing. (Tr. at 49-50).

Claimant's Exhibits 1-12

CX 1

Claimant submitted the medical records maintained by Dr. Gregory Charko. (CX 1). Dr. Charko's records include MRI tests. An MRI of the cervical spine was conducted on April 6, 2000, which showed a focal disc herniation at the C5-C6 level, with no compromise of the spinal or cord or nerve roots. (Also submitted as CX 11). An MRI of the left shoulder conducted on the same date revealed no evidence of fracture or subluxation, and normal marrow signal, and no evidence of tendinosis or tearing of the rotator cuff. It revealed hypertrophic (and enlargement) changes at the acromioclavicular joint, without significant impingement on the supraspinatus tendon.

Claimant has marked a letter dated April 25, 2000 as the medical opinion of Dr. Charko. This report summarizes the MRIs taken of Claimant's back from 1994 and 1999. Dr. Charko stated that there has been a progression of Claimant's low back problem from 1994 to 1999. He wrote that Claimant's current state was that he walks with a cane, has persistent sciatica, is undergoing treatment for his neck and shoulder, and has numbness in his hand. Dr. Charko stated that they had tried physical therapy, and he had suggested lumbar epidural blocks or surgery, but that Claimant was hesitant.

An MRI taken on April 26, 2000 of the right shoulder, which revealed no evidence of fracture or subluxation and normal marrow signal. (Also submitted as CX 12). The test did indicate tendinosis and/or a partial thickness tear of the supraspinatus tendon. It showed no impingement.

This exhibit also includes notes from several office visits from the year 2001 to 2005. On April 20, 2001, Dr. Charko reported complaints of neck pain with associated headaches, radiating pain in the left upper extremity and forearm and hand, persistent pain in both shoulders with a difficulty raising, and persistent back pain with radiating pain into the left leg with numbness. There was a positive Tinel sign at the left carpal tunnel. Dr. Charko discussed surgical procedures with Claimant, but felt Claimant was not psychologically stable due to the death of his mother. At the next visit, in September 2001, Claimant reported the same complaints. He told the doctor that he had joined a pool for the summer and was advised to keep exercising. Dr. Charko reported no new major medical problems.

On February 18, 2003, Claimant returned to Dr .Charko. Dr. Charko noted that Claimant was using a cane, and had a limp. He reported that Claimant could lift his arm "well overhead" on the right side. Dr. Charko reported that MRI findings did not indicate any impingement in the left shoulder cuff, but that his symptoms indicated shoulder impingement. He found no instability in the left shoulder upon examination. Dr. Charko noted that physical therapy had helped Claimant in the past, and that Claimant remained opposed to surgery. The following month Claimant returned with complaints of neck, left shoulder, left knee and low back pain. Claimant stated that "He feels a little more mobile and there is some less pain in his low back." He again complained of difficulty with overhead lifting, but stated that he went to physical therapy, which provided some relief. Dr. Charko found a mildly limited left shoulder abduction and tenderness in the left AC joint, but full range of motion on the right side. He also found a mild diminution in the range of motion of the neck. Dr. Charko recommended continued physical therapy, and a follow-up with an internist or a physiatrist, since Claimant continued to object to surgery.

On December 12, 2003, Dr. Charko recorded that Claimant stated he was limited in how far he could walk or how long he could sit. The last record of a visit was on December 5, 2005.

CX 2

An MRI of the left knee was taken on February 6, 2001. (CX 2). This test indicated a horizontal tear of the posterior horn of the medial meniscus, but does not indicate the length of the tear. There is also a Grade 2 signal myxoid degeneration within the posterior horn of the lateral meniscus.

CX 3

An EMG test was conducted on May 8, 2000. (CX 3). Dr. Steven Lomazow, who conducted the test, found negative Tinel's and Phalen's signs, symmetrical reflexes and no gross atrophy upon examination. The EMG was carried out on the bilateral upper extremities and associated paraspinal musculature. The test indicated a borderline prolongation of the left median nerve across the carpal tunnel segment. It also indicated a normal sensory latency and the remainder of the test was normal, including amplitudes, unit action potentials, and recruitment in all muscles. There was no evidence of denervation.

The assessment by Dr. Lomazow was the test suggested a mild entrapment of the left median nerve across the carpal tunnel segment, but that this should be considered in conjunction with the finding that there was a normal sensory latency.

CX 8

CX 8 is the MRI of the lumbosacral spine taken on June 14, 1994. The findings were a diffuse annular disc bulge at L4-L5, a central focal disc herniation at L5-S1 with minimal impingement upon the thecal sac, and narrowing of the intervertebral foramen at L4-L5 and L5-S1, with no evidence of impingement on the existing nerve roots.

CX 9

CX 9 is an MRI of the left knee taken on October 22, 1993, indicating a meniscal tear of the posterior horn or the medial meniscus and a signal on the posterior horn of the lateral meniscus.

CX 10

CX 10 is an MRI of the lumbosacral spine taken on August 10, 1999. There was a herniation at L5-S1 causing compression of the thecal sac, and a disc bulge at L4-L5 without evidence of thecal sac compression.

CX 13

Dr. Gregory Charko was deposed on April 10, 2006. He testified to treating Claimant since January 11, 2000. At that time, Claimant reported a 1992 work injury in the low back and knee. Claimant reported that he had arthroscopic surgery on the knee. He reported persistent back pain with left-sided sciatica. An MRI in 1994 showed mild stenosis at L4-5 and central disc herniation at L5-S1. He reported ongoing leg and knee problems, and that he had returned to work in 1996, whereupon he suffered another injury which aggravated his back injury and caused a shoulder injury. Claimant also complained of radiating pain to the left leg and numbness in the leg and foot. He also felt that the left leg had gotten smaller. MRI films from 1999 showed a greater herniation at L5-S1, impinging on the thecal sac (the sac that contains the nerve roots that go down the leg). (p. 5-7).

Upon examination, Dr. Charko found a limitation of shoulder abduction to 90 degrees. He found no gross weakness in the upper extremities, arms or hands. Dr. Charko found tenderness in the low back, particularly the left side. He noted that Claimant was using a cane to walk. Dr. Charko found a diminished calf circumference on the left, 15 5/8 as opposed to 16 1/4 on the right leg. Dr. Charko concluded that this atrophy was due to the long standing nerve root compression in Claimant's low back. (p. 8). The doctor found good range of motion in the knee and hips. He found degenerative changes in the left knee, and said once the pieces of the meniscus are removed, as was done in Claimant's surgery, the contact pressure between the joints increase and the joint surface wear increases.

Besides the back and leg pain, Dr. Charko found signs and symptoms consistent with impingement in both shoulders. (p. 9). Dr. Charko said the MRI of the left shoulder did not show a definite cuff tear, but that there was deterioration between the collarbone and shoulder blade, irritating the rotator cuff and causing impingement on the left side. The MRI of the right shoulder in 2000 showed partial thickness tear of the rotator cuff. (p. 11).

Subsequently, an EMG showed carpal tunnel syndrome in the left hand, and an MRI showed a herniated disc between the fifth and sixth vertebrae. Claimant complained of a little weakness in the left wrist extensor and grip. (p. 12).

Dr. Charko has diagnosed Claimant with a herniated disc at L5-S1 with lumbar radiculopathy, left shoulder AC joint arthrosis with impingement, a partial tear in his right rotator cuff with residual pain and weakness, and residuals in this left knee. Dr. Charko indicated a worsening of left knee, based upon a February 6, 2001 MRI which showed a horizontal tear of the posterior horn of the medial meniscus. (p. 13-14). The doctor indicated that this can happen when the knee deteriorates more often since the initial tear. (p. 14). Dr. Charko concluded that Claimant has a significant, permanent disability. Discussing his belief that the impairment is severe, Dr. Charko said:

> Well, I think it's significant because at this point the last time I saw him he told me he walks with a cane all the time, and then after just half a block he has to sit down and rest, he has knee problems, he's got the radicular pain. He told me when I last saw him that he gets radicular … pain on a pretty regular basis. He said he gets it daily, and he gets numbness in the left lower extremity at least three to four times per day, and it tends to last one to 10 minutes per time. His back pain was a, on a zero to 10 scale, he state the worse is a nine. Pretty substantial back pain. He's got ambulatory function between the knee and lumbar radiculopathy. He walks with a cane. After half a block he has to sit and rest, so not very functional at this point.

(p. 14-15).

Dr. Charko put restrictions on Claimant's walking, based upon Claimant saying he could only tolerate half a block, encouraging him to take frequent breaks. He also suggested limitations on bending and lifting. He indicated that a cane should be used for weakness and for protection against falling when his knee "locks."

Dr. Charko testified that the differences in findings between himself and Dr. Greifinger include: measurement of the calves, weakness and numbness in the leg, and the straight leg raising test. (p. 17-19). Dr. Charko stated that he has seen Claimant on fourteen occasions. (p. 18).

Dr. Charko testified that Claimant's condition has remained the same over the past six years of treatment. (p. 23). Dr. Charko indicated, that although he could not pinpoint it in his records, his recollection from seeing Claimant recently, is that Claimant's has a "little more difficulty" with the knee than he did six years ago. (p. 26-27). Dr. Charko indicated that while Claimant may not use his cane around the house, he always uses it when going for a walk outside the home or going to a shopping center, etc. (p. 27). He did not find the left shoulder or neck to have been injured relative to a work accident. He indicated the left shoulder may be a degenerative condition, and that he did not see specific mention of the neck in his records. (p. 28-29).

There was an improvement in the range of motion of the right shoulder. (p. 30). Dr. Charko indicated that it has "gotten a little bit better" over his course of treatment. (p. 31). The low back has not improved or worsened substantially, but the doctor feels it's a significant problem. Dr. Charko indicated that the left knee has worsened, in terms of Claimant's complaints of pain and his dysfunction. He stated this based upon Claimant's worsening ability

to walk, and that he is down to being able to walk only half a block. (p. 31). Dr. Charko testified that he had not seen the surveillance video of Claimant. (p. 34).

Dr. Charko concluded that Claimant is totally disabled, even from sedentary work due to his low back pain. He testified that his low back pain has been severe over the course of his treating Claimant, and that the nerve root compression predated his first examination of Claimant in January 2000. (p. 36-37).

Employer's Exhibits 1-4

EX 1

Dr. David Greifinger examined Claimant on September 10, 2001. (EX 1). He had been seen by Dr. Greifinger's office once before on March 27, 1997. Dr. Greifinger reviewed Claimant's medical records and conducted an examination. Claimant complained of pain in his entire left side, neck, headaches, low back and shoulders. When asked to actively engage during examination, Claimant exhibited weakness in the upper extremities, shoulders, and generally showed weakness in all musculature. However, upon passive examination, these appeared normal. Claimant complained of tenderness in all areas when his lumbar spine was examined; Dr. Greifinger opined that this indicated magnification. Testing during a sciatic stretch maneuver showed a positive result at 40 degrees bilaterally in a supine position, but a negative result at 90 degrees bilaterally when seated, indicating that the result was not truly positive and was embellished. Dr. Greifinger also did not find any gross atrophy of the lower extremities that would indicate disuse.

As regards the left knee, Dr. Greifinger noted:

> The MRI study of the left knee of 10/22/93 reflected tear of the medial meniscus extending into the inferior articular surface. Dr. Michael Wujciak addressed this surgically on 2/3/94. The follow-up MRI report of the left knee of 2/6/01 as per Dr. Brownstein spoke of horizontal tear of the medial meniscus extending to the inferior articular surface. This is similar in location to what was seen previously and a common finding following surgery. This would not necessarily reflect a new tear. Grade II changes were noted at the lateral meniscus, which were identified on the earlier study, as well.
>
> (p.8).

He found no evidence of effusion, ligamentous laxity or meniscal instability in the left knee.

Dr. Greifinger found that the MRI findings of the cervical spine on 4/6/00 matched that the clinical suggestion of normal neurological function he found in the upper extremities upon examination. The most recent MRIs of the shoulders revealed changes common in the general population, and did not indicate a full-thickness tear of the rotator cuff in the left shoulder. The 1999 lumbar MRI paralleled the findings found in the previous MRI from 1994.

Dr. Greifinger concluded that the Claimant's condition had not objectively worsened.

EX 2

Dr. Greifinger examined Claimant again on November 18, 2005. (EX 2). He again reviewed medical records and examined the Claimant. Claimant complained of worsening pain in his left wrist and paresthesia in the forearm to the hand. He also had complaint of pain in his right shoulder and lower back, with persistent pain in all positions including sitting, standing, walking and lying down. He also complained of pain radiating to his left thigh, leg and foot. His complaints of the left knee remained the same.

Upon examination, Dr. Greifinger did not find evidence of radiculopathy or myelopathy in the cervical spine, and normal rotation of the shoulders with passive motion and no evidence of rotator cuff dysfunction or instability. The doctor found full range of motion in the hands. There were inconsistent findings with sciatic tension signs, and no evidence of radiculopathy or myelopathy. He found no evidence of effusion, ligamentous laxity or meniscal instability in the left knee.

Dr. Greifinger concluded that Claimant did not exhibit any orthopedic changes since the last examination and did not require formal orthopedic treatment.

EX 3

EX 3 is the labor market survey conducted by Sharon Levine of SML Rehabilitation Consultants, Inc. on December 1, 2005. This report was the third requested to identify jobs for which the Claimant would be qualified given his medical status. The report utilized the 1998 findings by Dr. Zaretsky to establish the Claimant's restrictions. Those restrictions were: intermittent sitting for 4 hours a day, intermittent walking and standing for 3 hours a day, no lifting greater than 30 pounds, and no restrictions on the hands or feet. His level of work was identified as "low to medium." Approximately 41 positions were identified. The positions were comprised of mostly valet parking and driving positions, shuttle driving for car dealerships, security guard positions, and assembly line positions.

Ms. Levine concludes by saying that the jobs were identified since November 3, 2005, and are based upon the findings of Dr. Zaretsky and supported by Dr. Greifinger's findings.

EX 4

Employer's Exhibit 4 is a surveillance video, and a corresponding report detailing the events in the video. This video is shot over two days, November 8, 2005 and November 12, 2005. On the first date, Claimant was shown driving and walking, without utilizing a cane.

The video from the second date is more extensive, and spans the morning and afternoon. He also does not utilize a cane on this date. The video shows Claimant crossing the street with a child, exhibiting no limp. He gets in and out of his vehicle with no apparent difficulty. Claimant

kicks the car door shut at one point with his right foot, balancing on just his left leg. He and the child walk over to a field, Claimant strolling with his hands behind his back. Claimant kicks a soccer ball, and then apparently kicks it again and over a fence. He is walking on grass and stepping down curbs.

Later Claimant is seen filling water jugs. The first one he fills is the size of an office cooler jug. He fills the jug and carries it to his vehicle. He then takes several small jugs, fills them and carries a few at one time back to his car, where he puts them into his trunk. Claimant returns home where he uses a leaf blower; he uses both his right and left hand. He is seen talking to someone and then begins raking, grasping the rake with both hands. For almost thirty (30) minutes Claimant is blowing and raking the leaves. He never leans on anything for support while moving the leaves. He then is seen standing and speaking with neighbors for approximately thirty (30) minutes. Never once is Claimant seen leaning on something for support.

EX 5

Dr. Greifinger was deposed on March 13, 2006 in this matter. (EX 5). He testified to examining Claimant on three separate occasions, in 1997, 2001 and 2005. In 2001, Claimant complained of both shoulders, his low back and headaches, but did not complain of his left knee. Dr. Greifinger found both shoulders to be normal upon passive motions. However, weakness was exhibited on both sides, indicating there was no problem with the rotator cuff or any specific problem as that would result in a more specific problem, not a general weakness. (p. 17). The doctor found the rotator cuff to be functional and no evidence of instability in the shoulders. There was also no evidence of atrophy in the right shoulder or right upper extremity. Claimant reported that his symptoms with his shoulders were unchanged when he saw Dr. Greifinger again in 2005. The doctor testified that his findings and the Claimant's complaints were similar in both the 2001 and 2005 examinations.

Dr. Greifinger examined Claimant's left knee in 1997 and found only healed anthroscopic scars from Claimant's 1993 surgery with Dr. Wujak. He heard some creaking (crepitation), which was due to changes of degenerative joint disease. Otherwise, the ligaments were stable, although Claimant complained of tenderness. Dr. Greifinger's examination of the knee in 2001 was the same except that Claimant did not complain of tenderness at this time. (p. 22). The exam was negative, except for the scarring. The thighs showed an insignificant difference in size, and the calves were symmetrical. In 2005, Claimant complained of the left knee, but said he was unchanged overall. He complained of atrophy in the left knee, but again Dr. Greifinger found no significant disparity as compared with the other leg. The doctor only heard crepitation on the first examination in 1997. Otherwise, the ligaments and menisci were the same upon subsequent examinations.

MRIs were conducted of the knee, but Dr. Greifinger explained that post-surgery these films are harder to interpret for changes, and the MRIs showed the same thing pre and post surgery (a tear or possible tear), so the emphasis should be on the examinations to determine if there has been a change. The McMurray maneuver, where the physician listens for a clicking

sound to indicate instability of the meniscus, was negative. Overall, Dr. Greifinger found no suggestion of an active, ongoing problem of the left knee. (p. 26-27).

At his first examination in 1997, Claimant exhibited a marked restriction in his forward flexion. He also showed global weakness in the legs, which Dr. Greifinger testified is not what one would see if there was a specific problem with the lumbar spine. Instead this global weakness in the legs indicates a lack of effort and volitional weakness. (p. 29). In 2001, Claimant complained of paresthesias in the left leg to the ankle. However, he had inappropriate responses to tests, which did not indicate sciatica. Again, he exhibited global weakness, and again the doctor explained how if one had acute herniated discs, or acute sciatica, there would be a specific weakness. (p. 32). Claimant also had inconsistent straight leg raising tests (where the test was positive lying down, but negative sitting up), which made the doctor question the truthfulness of the complaints.

In 2005, Claimant reported to Dr. Greifinger that his low back pain was worse than ever. He complained that it bothered him in all positions. He denied paresthesias at this examination. Again, there was an inconsistency in the straight leg raising test. (p. 37). Claimant said he needed a cane 99% of the time and had a limp. Dr. Greifinger did not see any change in the back. Claimant had a normal heel-toe pattern, meaning he could stand on both his toes and heels. Dr. Greifinger reviewed MRIs, which indicated bulges and a herniation at L5-S1. (p. 66). He testified that bulges and herniations only become clinically significant when they are hitting a nerve structure. Here there is a small herniation, but no nerve root encroachment. Dr. Greifinger said there was a change from the first MRI (no definite impingement on nerve root) to the second MRI (nerve roots were obliterated bilaterally). He testified that this can cause symptoms such as radiating pain. (p. 75).

Dr. Greifinger testified that based upon the medical records and examinations, he found that Claimant could return to work as a checker without restriction or could engage in sedentary or light duty employment. (p. 41). He testified that his finding was reinforced by the videotape surveillance of Claimant, in which the Claimant performed various tasks and did not use a supportive aid nor exhibit an altered gait. (p. 44).

EX 6

Sharon Levine, a vocational rehabilitation consultant, was deposed on April 10, 2006. She based her assessment in this case on the findings of Drs. Greifinger and Zaretsky, which were intermittent sitting up to four hours per day, intermittent walking up to three, intermittent up to three, and a lifting restriction of thirty pounds. (p. 10-11). Ms. Levine's labor market survey, in this case, targeted sedentary to light work. She compiled three reports, dated July 1997, March 1998, and December 2005. The latest report is included as EX 3. The report dated 2005 identifies jobs that were available from 1999 to 2005, although some may not be currently available. (p. 17-19).

I. MODIFICATION

Section 22 of the LHWCA allows for any party-in-interest, within one year, to request modification of a compensation award based upon a mistake of fact or change in condition. 33 U.S.C. § 922. The purpose is to render justice under the Act, and therefore the trier of fact has broad discretion in deciding whether to modify a compensation order. Finch v. Newport News Shipbuilding & Dry Dock Co., 22 BRBS 196 (1989); O'Keefe v. Aerojet-General Shipyards, 404 U.S. 254 (1971).

As this is a request for modification, the instant claim must be denied unless the additional evidence demonstrates that one of the applicable conditions of entitlement has changed since the denial of the prior claim or if the evidence of record demonstrates a mistake in a determination of fact. § 725.310(c).

Here, Claimant argues that modification is justified on the basis of mistake of fact and change in condition.

A. There Is No Evidence of a Mistake of Fact

Generally, the threshold determinations for modification based upon a mistake of fact are:

1) Whether there was a mistake by the original fact-finder, and
2) If so, whether the mistake was a mistake of law or fact.

Only mistakes of *fact* allow for modifications. Modifications require re-opening the record to allow for new evidence. Moore v. Washington Metro. Area Transit Auth., 23 BRBS 49 (1989).

Claimant's request for modification based on mistake of fact concerns the job duties of a checker (Claimant's pre-injury position). I previously found that Claimant was able to perform the duties required of him as a checker and able to return to work. Claimant testified extensively at the most recent hearing, on January 18, 2006, about his job duties with Universal. (See hearing transcript). This testimony articulates his job duties with more specificity than before. Without stating that this evidence would have impacted my finding, it is certainly new evidence that was available to the Claimant when these matters were litigated before. This issue was already litigated. It is not up for review on modification; any new information about Claimant's job is neither a change of condition nor a mistake of fact.

When one alleges a mistake of fact, they are alleging that there was a mistake based upon the facts before the court. Claimant has not shown there was a mistake of fact based upon the evidence that was before this Court. In Kinlaw v. Stevens Shipping and Terminal Co., 33 BRBS 68 (1999), the ALJ found in her original order that the claimant was unable to perform his job as a flagman/footman. In finding so, the ALJ discredited the finding of a doctor witness who stated claimant was capable of performing his job. Id at 69. The employer filed a motion for modification, submitting a letter in which the doctor expounded on his prior testimony, reaffirming that claimant was capable of performing his job duties. Id. The ALJ denied the

request for modification, finding that the employer should have anticipated the need to develop the doctor's testimony at the initial hearing, and that reopening the case was not in the interest of justice and defeated the principles of finality and judicial efficiency. Id. at 71, 74.

The Board in Kinlaw affirmed the ALJ's decision. The Board relies on the findings in McCord and O'Keefe that an allegation of a mistake of fact should not allow for a back door route for retrying a case. Kinlaw, 33 BRBS at 72 (citing McCord v. Cephas, 532 F.2d 1377, 1380-1381 (D.C. Cir. 1976), rev'g 1 BRBS 81(1974)). Recognizing that the basic criterion of re-opening a case under Section 22 is whether it will "render justice under the act," the court of appeals in McCord wrote:

> The congressional purpose in passing the law would be thwarted by any lightly considered reopening at the behest of (a party) who, right or wrong, could have presented his side of the case at the first hearing and who, if right, could have hereby saved all parties a considerable amount of expense and protracted litigation.

Kinlaw, at 72 (citing McCord, 532 F.2d at 1380-1381, 3 BRBS at 376-377). Just as in Kinlaw, the movant, here the Claimant, has failed to meet his initial burden of establishing that the evidence produced would bring the case within the scope of Section 22, because the evidence is something that should have been developed previously. Id. at 73. Only in cases of *newly* discovered evidence *must* an ALJ re-open the record. Dobson v. Todd Pac. Shipyards Corp., 21 BRBS 174 (1988); Delay v. Jones Washington Stevedoring Co., 31 BRBS 197 (1998)(Board found ALJ abused discretion in not reopening a case where there was newly discovered evidence, not available at the time of the hearing). Otherwise, the decision to reopen a case under Section 22 is discretionary, and is based upon the competing interests of the need for rendering justice and the need for finality. Kinlaw, 33 BRBS at 73.

Based upon the evidence, I find that Modification based upon a mistake of fact is not warranted in this case.

B. There Is Sufficient Evidence to Establish a Change of Condition of the Low Back

Claimant also requests modification based upon a change in condition, arguing that his condition has worsened since March 1999 (the date of my previous Order). At that time, Claimant was awarded temporary total disability from May 10, 1996 to March 27, 1997, partial scheduled disability of the left leg for 28.8 weeks compensation, and associated medical expenses. It was determined that Claimant reached maximum medical improvement (MMI) on May 22, 1998.

With regard to change in conditions of entitlement, I must initially determine if the petitioning party has shown, by way of new evidence, that there has been a change in the claimant's condition since the entry of the award. Jensen v. Weeks Marine, Inc. (Jensen II), 34 BRBS 147 (2000); See also Rizzi v. Four Boro Contracting Corp., 1 BRBS 130 (1974). Only after it is determined that the new evidence brings the claim within the scope of Section 22 must

I consider all the evidence of record and determine if there was a change in condition (and therefore a basis for a modification); the usual standards for determining an award apply.

Claimant argues that there has been a worsening of his condition since 1999. He had previously alleged injuries to his left knee, low back, and right shoulder. It was determined that Claimant was temporarily disabled and was entitled to a scheduled injury for 10% of his left leg (due to the knee injury) for a finite number of weeks. It was determined at the time of the hearing that he could return to pre-injury work. Now he also alleges injuries to his hands, left shoulder and neck, stemming from his work accident. Employer argues that these injuries alleged since the last hearing should not be discussed presently. Modification does not allow for re-examination of the causal relationship between an accident and an injury, absent the showing of a mistake of fact. Thompson v. Quinton Eng'rs, Inc., 6 BRBS 62 (1977). Even assuming arguendo that these injuries were being considered at this point, they would not affect the outcome, as Claimant's own physician, Dr. Charko, testified that they do not stem from the work accident. (See CX 11 at p. 28-29).

The main focus of this modification claim is the left knee and low back. There is no indication from the medical evidence that there has been a change in condition of the right shoulder. Dr. Charko testified that the right shoulder has actually improved in the time he has been treating Claimant. (CX 11 at p. 31). There is no medical evidence submitted that establishes a change in condition of the right shoulder.

At the time of the prior award, an MRI showed a meniscal tear of the posterior horn of the medial meniscus in the inferior articular surface of the left knee. It also showed an intramenical signal in the posterior horn of the lateral meniscus. Surgery was performed on the knee in 1994. Post-award, an MRI has shown a horizontal tear of the posterior horn of the medial meniscus in the inferior articular surface. It also showed myxoid degeneration, Grade II signal, within the posterior horn of the lateral meniscus. These two MRIs, one prior to the award and one subsequent to it, indicate the same problem. Even though surgery had been performed on the knee, the post-surgery MRI does not necessarily reflect a new tear, as explained by Dr. Greifinger. The Grade II changes (which are not a tear) were seen in both MRIs. Dr. Charko also points to a difference in calf circumference to show atrophy of the leg, and therefore a worsening of condition. However, the same atrophy of ½ an inch was found by Dr. Zaretsky prior to the award, as was discussed in my D&O. Dr. Charko opined that the left knee has worsened, based upon the Claimant's complaints and his level of dysfunction. This, however, does not establish a change in condition, as discussed below.

An MRI of Claimant's low back from 1994 showed a diffuse annular disc bulge at L4-L5, a central focal disc herniation at L5-S1 with minimal impingement upon the thecal sac, and narrowing of the intervertebral foramen at L4-L5 and L5-S1, with no evidence of impingement on the existing nerve roots. An MRI conducted in 1999 showed a herniation at L5-S1 causing compression of the thecal sac, and a disc bulge at L4-L5 without evidence of thecal sac compression. Dr. Charko testified that the more recent MRI indicates a greater herniation at L5-S1 than was present in 1994. (CX 11 at p. 5-7). His medical opinion report (CX 1) states:

> The MRI of 1999 of the lumbar spine clearly shows a substantial disc herniation to the left of mid-line at L5-S1 which does impinge against the thecal sac. The MRI of 1994 just showed a central disc herniation. The MRI of 1999 clearly shows progression of his disc herniation, it is now protruding to the left side, and is certainly impinging against the thecal sac and causing lateral recess stenosis.

(CX 1)

Dr. Greifinger likewise testified that there was a change from the first MRI which showed no definite impingement on the nerve root, to the second where the nerve roots were obliterated bilaterally. He testified that this can cause radiating pain. (EX 5 at p. 75). I find that this evidence is sufficient to establish a change in condition of the low back, and therefore the claim is within the scope of Section 22.

II. NATURE AND EXTENT OF DISABILITY

Now that I have determined that Claimant has established a change in condition sufficient to bring his claim under Section 22, I must determine if this change in physical condition results in a change in a condition such that there is a basis for modification. The usual standards for determining the level of disability apply.

Total disability is defined as complete incapacity to earn pre-injury wages in the same work as at the time of injury or in any other employment. To establish a *prima facie* case of total disability, Claimant must show that he cannot return to his regular or usual employment due to his work-related injury. If Claimant meets this burden, Employer must establish the existence of realistically available job opportunities within the geographical area where Claimant resides which he is capable of performing, considering his age, education, work experience, and physical restrictions, and which he could secure if he diligently tried. Mills v. Marine Repair Service, 21 BRBS 115, 117 (1988); American Stevedores, Inc. v. Salzano, 538 F.2d 933 (2d Cir. 1976), aff'g. 2 BRBS 178 (1975); McCabe v. Sun Shipbuilding & Dry Dock Co., 602 F.2d 59, n.7 and related text (3d Cir. 1979).

A disability is permanent when the claimant reaches the point of maximum medical improvement (MMI). James v. Pate Stevedoring Co., 22 BRBS 271, 274 (1989); Phillips v. Marine Concrete Structures, 21 BRBS 233, 235 (1988). The date of MMI is a medical determination to be based upon the medical evidence of record. The evidence must show a date on which a claimant has received maximum benefit from medical care, such that his condition is no longer improving. Usually, a Claimant will not be declared permanently disabled where there is impending surgery

In my prior Order of 1999, I found that Claimant had sustained an injury, and was temporarily totally disabled for a period, but was currently able to return to work. He was also awarded a partial scheduled injury for his left knee. I credited Dr. Greifinger for the date which the temporary total award was to end, March 27, 1997, as it was determined that Claimant was capable of returning to work and earning pre-injury wages. So the inquiry here is whether the change in condition to the low back, as established by way of the 1999 MRI which shows the

herniation compressing on nerve roots, has created a change in a condition of entitlement upon which Claimant was previously denied. In other words, what is the level of Claimant's disability now?

Claimant testified to an overall worsening of his condition since 1997. (Hearing testimony at p. 24). Particularly his back pain and left knee have worsened. He began seeing Dr. Charko in 2000, who recommended surgery on his back and knee, but Claimant is afraid to have the surgeries. He testified that he can not stand, sit or pay attention, and that this is preventing him from working. However, he testified that he has seen improvement in his walking, and that now he can walk more than a block. This directly contradicts Dr. Charko's assessment that Claimant's ability to walk has deteriorated to less than one block. See Hearing transcript at p. 35-36; and See CX 11 at p. 15. Claimant also testified that while at the last hearing he could not sit more than ten minutes, he could at the present hearing.

Claimant has testified to using a cane a majority of the time. He told Dr. Charko, and Dr. Charko testified to such, that he uses the cane about 99% of the time. Claimant also testified to having a constant limp. (Hearing transcript at p. 37-38). Dr. Charko testified that he based his opinion of a worsened injury to the knee on Claimant's subjective complaints, such as not being able to walk more than half a block (contradicted by Claimant's own testimony) and using a cane 99% of the time. Dr. Charko also testified that he has not seen the surveillance video of the Claimant.

The crux of this case is credibility. Credibility is particularly important here because although I have found a worsened medical condition of the low back based upon recent MRI results, the question now is the effect this has had on Claimant. That is, has the increase in a herniation affected the Claimant's ability to work such that he is actually in a different condition than he was at the time of the 1999 Order? An Administrative Law Judge is the fact finder and "is entitled to consider all credibility inferences." Mendoza v. Marine Personnel Co., Inc., 46 F.3d 498, 500 (5th Cir. 1995)(citing Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir.1988)). The ALJ determines the weight to be accorded to evidence and makes credibility determinations based upon the record. Mijangos v. Avondale Shipyards, 948 F.2d 941, 945 (5th Cir.1991).

I find that the Claimant is not credible. This is largely due to the surveillance video in this case. While I certainly recognize that a Claimant has the right to go about daily life, and make an effort to take care of chores as best as is possible given his medical condition, here the Claimant's actions directly contradict his own testimony. Claimant testified that he utilizes a cane 99% of the time. He testified that he needed it in case he felt unstable. Dr. Charko testified that it was for weakness and protection from falling when his knee periodically would "lock." However, the Claimant does not use a cane at any point in the video. If a cane is to protect the Claimant from suddenly falling, then it would be used all the time. Claimant strolls with his arms behind his back, which is not indicative of a person so afraid that they might suddenly fall that they need a cane. He kicks a ball over a fence, and kicks his car door shut with his right foot while standing on only his left. He crosses the street briskly and without exhibiting the constant limp he testified to having. He grasps a rake with both hands, and uses a leaf blower with both his right and left hand. Except for briefly leaning on a car while speaking with someone inside

it, Claimant is never seen leaning on anything for support. Therefore, I can not rely on Claimant's testimony that his abilities have worsened such that he can now not perform such tasks as he was deemed to be able in 1999.

Accordingly, I do not accord much weight to Dr. Charko's medical opinion. First of all, the evidence submitted as his medical opinion, CX 1, is the opinion that the doctor rendered prior to actually treating the Claimant. Subsequent to this medical opinion are his treatment records, which indicate no worsening of Claimant's problems, and in fact some improvement. There are also findings contrary to those which the doctor used to make his initial opinion. Secondly, the doctor relied heavily on the Claimant's subjective complaints. I cannot credit medical opinion based upon this because I have discredited Claimant's testimony. Interestingly, Dr. Charko also testified that Claimant's condition has not changed much over the past six years, and that specifically the low back has not worsened. (CX 11 at p. 23, 31).

The medical evidence here shows a worsening of the medical condition of the low back. All other evidence, however, shows no impairment. The physician who opined that Claimant was impaired based his opinion on Claimant's subjective complaints and what he exhibited volitionally in the doctor's office. This is clearly contradicted by surveillance video and Claimant's own testimony. Claimant says he uses a cane; he does not. Claimant says he has persistent back and knee pain and has extreme difficulty walking; Claimant is seen walking and standing for long periods of time without any sign of difficulty. Claimant says he has a limp; he does not. Claimant says he has carpal tunnel syndrome so that he has trouble grasping; Claimant is seen utilizing different tools, grasping them with both hands.

Unlike Dr. Charko's medical opinion, Dr. Greifinger's opinion is consistent with the medical findings *and* supported by the Claimant's actions. Dr. Greifinger's opinion is that Claimant is not disabled. He places no restriction on Claimant in relation to his former position as a checker, finding that he is able to return to this work, or in another sedentary or light duty position. Employer has provided evidence of such work. These are substantially the same as the positions put forth at the prior hearing, but as I have found that the Claimant has not had a change of condition in his disability status, I do not reach the issue of Suitable Alternative Employment.

ORDER

Based upon the foregoing findings of fact, conclusions of law and the entire record, I find that Claimant's Motion for Modification should be **DENIED**.

A

PAUL H. TEITLER
Administrative Law Judge

Cherry Hill, New Jersey